



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

LESLIE JENNINGS MD

Respondent Name

SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number

M4-16-0502-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Gallagher Bassett continues to deny services saying that authorization was denied when they don't require authorization, nor did we try to obtain authorization for services that don't require one. This patient was seen for their compensable injury. An office visit and cortisone injection was billed."

Amount in Dispute: \$355.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Division placed a copy of the Medical Fee Dispute Resolution request in Safety National Casualty Corporations Austin representative box, which was acknowledged received on November 3, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 24, 2014	99214, 20610 and J0702	\$355.00	\$198.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §134.203 sets out the Medical Fee Guidelines for Professional Services.
4. 28 Texas Administrative Code §134.1 sets out the Medical Reimbursement Policies.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 1 – Non Certification determination based on UR outcome.
 - 2 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3 – Request for reconsideration.
 - 1 – Matching authorization record is non-certified.

Issues

1. Are the dispute services subject to 28 Texas Administrative Code 134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99213 and 20160 and HCPCS Level II Code J0702 rendered on November 24, 2014. Safety National Casualty Corporation's audit company, Gallagher Bassett, denied the disputed services with denial reason codes, "1 – Non Certification determination based on UR outcome, 2 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly, W3 – Request for reconsideration, 1 – Matching authorization record is non-certified."

Per 28 Texas Administrative Code 134.600, the disputed services are not subject to preauthorization. The Division finds that Safety National Casualty Corporation did not respond to the Medical Fee Dispute. Absent any denial, rejection, or other insurance carrier defenses raised that conform with the requirements of Title 28, Part 2, Chapter 133, Subchapter C, including 28 Texas Administrative Code §133.240, the division finds that the service in dispute is eligible for payment.

2. The Division finds that the requestor is entitled to reimbursement for CPT Codes 99213 and 20160 and HCPCS Level II Code J0702 rendered on November 24, 2014. The MAR reimbursement is determined as follows:

Per 28 Texas Administrative Code 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code 134.203 (c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

- The MAR reimbursement for CPT Code 99213 is \$89.90. Therefore, this amount is recommended.
- The MAR reimbursement for CPT Code 20610 is \$108.33. Therefore, this amount is recommended.

The Division finds that the requestor is entitled to a total reimbursement of \$198.23 for CPT Codes 99213 and 20610.

28 Texas Administrative Code 134.203 (d) states in pertinent part, “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS. (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

28 Texas Administrative Code 134.203 (f) states, “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §134.1 (f) states, “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

The requestor seeks reimbursement for HCPCS Level II Code J0702 not valued by Medicare and Texas Medicaid. As a result, the dispute charge is subject to 28 Texas Administrative Code 134.1. The Division finds that the requestor submitted insufficient documentation to support that \$10.00 is a fair and reasonable reimbursement for HCPCS Level II Code J0702. As a result, reimbursement cannot be recommended for this code.

3. The Division finds that the requestor is entitled to reimbursement for CPT Code 99213 and 20610 in the amount of \$198.23.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$198.23.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$198.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	February 12, 2016 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.